When this form is completely filled out use Preventive Medicine Services Code: 99381—New Patient < one year 99391—Established patient < one year

	99391—Established patient < o	ne year				
6 M EPSDT Screening Date	200	Member ID#				
6 Month Visit						
Name	Birth Date		Historia	n		
Age Allergies		Medicat	tions			
					m 5	_
Weightlbsoz. Le	ength inches F	lead circ.	cm	Temp	T R	ζ
	Physical Exam (UNC	LOTHED	Ves No)	= nl	X = abnl	
Nutrition	General \Box		10)	- 	71 — QD 111	
☐ Breasttimes per day.	Head	=				
	Fontanel Neck					
☐ Formulaoz . per day	Eyes					
Brand	Red reflex					
With iron? Yes No	Alignment	l				
Water: city well spring bottled	Ears					
Cereal/baby food Yes No	Nose					
Compined non-deri	Throat/Mouth/Teeth Lungs					
Servings per day WIC: yes no	Heart					
History Update	Abdomen					
Are there any changes in your family	Femoral Pulses	l				
history? No Yes	Genitalia					
	Female					
	Testes					
Has the patient had any new problems	Extremities \Box					
or illnesses since the last visit?	Hips □	1				
No Yes	Spine					
	Skin Neuro					
	Neuro					
Problems/Concerns	Safety		mpression			
Constipation yes no	☐ Car seat, facing backward		Well Baby, no	ormal growth a	.nd developme	ent
Sleep yes no	☐ Smoke detectors in home ☐ Hot water < 120 degrees		ì			
Diaper rash yes no	Rolling over, fall prevent					
	☐ No baby walkers)			
	Child proof home					
	☐ Always supervise bath					
Hearing/Speech	☐ Sun exposure Health/Nutrition	-	Plan/Refer		IDV/	
Responds to sounds yes no	Continue formula or brea			7, Hib, Hep B rmation Sheet	, IPV	
Jabbers and laughs yes no	☐ Introduce meats, finger f			ienm	2. a 4 hrs.	
Vision:	☐ Introduce cup, juice		☐ Six month H		5. 1	
Looks at parent's face yes no Follows with eyes yes no	☐ Avoid honey		RTC at 9 mo			
Developmental Screen*	☐ Teething / clean teeth		☐ Fluoride gtts.	O.25 mg dail	. y	
normal abnormal	No bottle in bed or bottle		1			
Lead Risk Factors*	propping Social/Behavioral	_	<u> </u>			
yes no	Temperament		ì			
	☐ Sleep, bedtime routine					
*see separate form	☐ Talk, read to baby	_			M.D. / P.	.N.P.
	☐ Family support		☐ See back for additional documentation			
	☐ Day care yes no					
		Provider			\Box	\Box
		ID#				